Iowa Operations
4149 Highline Blvd, Suite 200
Oklahoma City, OK 73108

PHYSICIAN'S TRANSPORTATION RESTRICTION FORM

Please Fax Form Back To: 866-277-8959

The purpose of this form is for a physician to communicate to LogistiCare specific transportation restrictions of a patient / Member due to a medical condition. The restrictions and requirements stated on this form will be used by LogistiCare to determine the best means of transportation for the patient / Member.

Today's Date: ________________

Patient / Member Information:

Name: __________________________________ Address: ______________________________________

Medicaid ID Number: _______________________ DOB: ____________ Phone: _____________________

Transportation Needs: *(Please check all that apply; must be completed by physician)*

☐ Member is receiving medically necessary for a Medicaid covered service.

☐ Patient / Member is medically unable to walk ¾ mile.

☐ Patient / Member is medically unable to be driven by friend or family member.

☐ Patient / Member is medically able to use public transportation (e.g., bus or other public mass transit) ONLY if accompanied by an aide/companion. (If so, LogistiCare will make accommodation for the aide/companion fare, but LogistiCare does not provide the aide/companion.)Patient is unable to use public transportation because:

____

☐ Patient is Paratransit certified and has Paratransit ID.

☐ Does patient / member have a wheelchair*? Yes** / No Type: Manual / Electric / Scooter
Size of Wheelchair: __________________________
*(*LogistiCare does not provide wheelchairs or scooters.*)
**Is patient / Member able to transfer without assistance? Yes / No

☐ Patient Member is able to sit up on his/her own. Yes / No

☐ Patient /Member uses a cane/walker. How many feet can patient / Member walk using this equipment? _____

****Describe the specific medical condition(s) directly related to the patient's / Member's need for a higher level of service other than public transportation:**

____

Is the period of incapacity permanent? Yes / No

If not, the expected expiration date of restrictions: ___________________________________

Physician Information:

NAME: ____ **TELEPHONE:** ______________________

SIGNATURE OF PHYSICIAN: ____________________________ **DATE:** _________________________